

## Healthcare Interpretation Task Force – Interpretations

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### 1. Fire damper testing exemption

**Question:** Is it acceptable to exempt a fire damper from the four-year maintenance and test requirement where the physical limitations cause the damper to be inaccessible?

**Background Information:** Effective 1993, NFPA 90A requires maintenance of fire and smoke dampers, once every 4 years. In conducting these tests and maintenance several fire dampers were discovered totally inaccessible due to added utilities.

**Answer:** Yes, NFPA 90A – 1999 Edition: 1-3.2 and NFPA 101(2000 ed): 4.6.3 both contain provisions to allow alternative methods to be considered. As an example of this, the HITF notes the following text that is found in the 2000 edition of NFPA 101.

4.6.3 Modification of Requirements for Existing Buildings. Where it is evident that a reasonable degree of safety is provided, the requirements for existing buildings shall be permitted to be modified if their application would be impractical in the judgment of the authority having jurisdiction.

Interpretation from May 16, 2000 HITF Meeting

### 2. Locking doors in the means of egress of health care facilities

**QUESTION:** Was it the intent of the Life Safety Code prior to the 1988 Edition to permit doors in the means of egress of health care facilities to be locked where the clinical needs of the patients required specialized security, provided staff can unlock the doors at all times?

**Background Information:** Prior to the 1988 edition of the *Life Safety Code*, the code only permitted doors in the required means of egress of a health care facility to be locked

with time delay type locks or in mental health facilities with keys. The more recent editions of the code now refer to the clinical needs of the patient and do not limit key locking to just mental health facilities.

For example, today's nursing homes have Alzheimer's units or wings. Alzheimer's is not a mental health condition and was not identified prior to the mid 1980's other than through vague terminology such as "senility" or "dementia".

AHJ's using editions of the *Life Safety Code* prior to 1988 are not permitting nursing homes to lock Alzheimer's units other than with time delay locks (special locks) because they are not mental health facilities. Time delay locks are totally inadequate for Alzheimer's patients. Alzheimer's patients have no idea that their pressing on the panic bar is the cause for the alarm and the locks eventually open without staff interceding. The constant alarming only causes the staff to disconnect the systems.

ANSWER: YES. Locking of these doors is acceptable provided: The clinical needs of the patients require specialized security measures for their safety; and Staff can readily unlock such doors at all times.

*Interpretation from September 10, 1998 HITF Meeting*

### **3. Undercut of non-rated corridor doors**

QUESTION:

Is it the intent of 12-3.6.2.1 and 13-3.6.3.1 to require conformance with NFPA 80, *Fire Doors and Windows* for non-rated corridor doors?

Would a non-rated corridor door, provided with an average 1 inch undercut, be an acceptable arrangement?

NOTE: While this interpretation is rendered based upon the 1997 edition of the Life Safety Code – NFPA 101, it should be noted that this interpretation is also applicable to the 1985, 1981, 1973 and 1967 editions of the code.

ANSWER:

NO

YES

*Interpretation from September 10, 1998 HITF Meeting*

### **4. Fire Watch – use of normal clinical staff**

QUESTION: Can the normal clinical staff in an area affected by a fire alarm impairment or a sprinkler system impairment be used to satisfy the requirements for a fire watch? (NFPA 101, 1997 Edition)

ANSWER: YES. Clinical staff may fulfill this role provided, as determined by the authority having jurisdiction, there is an adequate staffing level to continuously patrol the affected area and that they have the means to make proper notification to other occupants in the event of a fire.

*Interpretation from September 10, 1998 HITF Meeting*

## **5. Fire Drills – are 50% required to be unannounced?**

Interpretation 98-4 NFPA 101, 1997 Edition<sup>1</sup>. Section 1-7.5

### Background Information:

This section of the Life Safety Code does not specifically address what percentage, if any, of fire drills must be announced or unannounced. This section expects fire drills to be held at both expected and unexpected times but does not specifically require more unannounced drills than announced fire drills.

Recently, JCAHO stated that at least 50% of the fire drills must be unannounced although this requirement is not part of their EC standards. (See Healthcare Fire Protection Newsletter, October 1998, Volume 4, No. 10, page 11 as quoted by Janet McIntyre, spokesperson for the JCAHO). This is their interpretation of section 1-7.5.

### Question:

Does Section 1-7.5 require that 50% or more of the fire drills conducted be of the unannounced type?

### Answer:

NO. Each authority having jurisdiction may establish a percentage of unannounced drills as appropriate for the circumstances. For example, JCAHO has recently indicated that at least half of the fire exit drills should be conducted as unannounced drills. Regardless of this, no drill should ever jeopardize the welfare of the patient receiving care.

*Interpretation from November 17, 1998 HITF Meeting*

## **6. Charting areas open to the corridor**

Interpretation 98-5 NFPA 101, 1997 Edition. Section 12-3.6.1/13-3.6.1

### Background Information:

In many health care settings, charting areas for use by nurses are provided in corridors. These spaces are open to the corridor and are not enclosed. They are in addition to and often not visible from nursing stations. They range in size from a small desk in an alcove to large rooms and sometimes have several racks/shelves of paper records and/or x-ray film. Generally, they are not occupied at all times. Sections 12/13-3.6.1 requires corridors to be separated from all other areas but allows several exceptions such as nursing stations to be open to the corridor. The 1997 edition of the Life Safety Code Handbook states in the explanatory commentary that...."Areas used for charting and communications by doctors and nurses are permitted to be open to the corridor." Some AHJs are confused whether this statement in the LSC HB is universally applied.

### Question:

Is it acceptable to have charting areas that are not part of a nursing station open to a corridor in a health care occupancy in accordance with 12/13-3.6.1, Exception No. 3?

### Answer:

NO. However, if such spaces can be protected using any of the options in:

101: 12-3.6.1, Exception No. 1; or

101: 13-3.6.1, Exception No. 1; or

101: 13-3.6.1, Exception No. 6

such spaces can be open to the corridor.

*Interpretation from November 17, 1998 HITF Meeting*

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<sup>1</sup> NOTE: While this interpretation is rendered based upon the 1997 edition of the Life Safety Code, it should be noted that this interpretation is also applicable to the 1994 Edition of the code.

## **7. Positive latching requirements for corridor doors to hazardous areas**

Interpretation 98-6 NFPA 101, 1997 Edition. Section 13-3.6.3.2

### Background Information :

Some AHJs require that doors to hazardous areas off of a corridor in existing health care occupancies be provided with positive latching. Section 13-3.6.3.2 of the Life Safety Code requires doors to be provided with means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. It does not state that latching is specifically required. The means used must be capable of keeping the door fully closed if a force of 5 lbf is applied at the latch edge of the door. The appendix note to 13-3.6.3.2 states that a number of options exist for patient sleeping room doors such as ...."Doors protecting openings to patient sleeping rooms or treatment rooms, or spaces having a similar combustible loading might be held closed using a closer exerting a minimum closing force of 5 lbf on the door latch stile." Although the appendix note does not address doors to hazardous areas off corridors, some AHJs permit a self-closing device to serve as the means for keeping the door closed. For sprinkler protected hazardous areas in existing health care occupancies, Section 13-3.2.1 requires doors be equipped with self or automatic closers.

### Question:

Is positive latching required for corridor doors to hazardous areas that are sprinkler protected in existing health care occupancies?

### Answer:

NO. Provided that a self-closing or automatic closing device is installed on the door and that such device can meet the 5 pounds (force) criteria of 101: 13-3.6.3.2.

*Interpretation from November 17, 1998 HITF Meeting*

## **8. Two exit signs visible in an exit corridor**

Interpretation 98-7 NFPA 101, 1997 Edition. Section 5-10.1.4

### Background Information :

Section 5-10.1.4 requires that access to exits be marked by approved readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. It further states that sign placement shall be such that no point in the exit access corridor is more than 100 feet from the nearest sign, with an exception for existing buildings. Some AHJ's interpret this to require two exit signs to be visible from any location in an exit access corridor, even in existing buildings.

### Question:

Must two exit signs always be visible from any location in an exit access corridor per Section 5-10.1.4?

### Answer:

NO

*Interpretation from November 17, 1998 HITF Meeting*

## **9. Floor plans showing evacuation routes**

### **NFPA 101, 1985 and Subsequent Editions.**

Background Information: Many Authorities having Jurisdiction (AHJ's) require floor plans showing evacuation routes to be posted on each floor of a healthcare facility. The AHJ's often cite Sections 31-4.1.1 and 31-4.2.2 of the 1985 edition of NFPA 101 and similar sections in other editions of the Life Safety Code. For example, HCFA's Fire Safety Report for the 1985 Code in K48 states "A simple floor plan showing the evacuation routes is posted in prominent locations on all floors. 31-4.1.1, 31-4.2.2"; however, the referenced Code section does not specifically require these evacuation plans.

Question: Does the Life Safety Code require that floor plans showing evacuation routes be posted on all or any floors of a healthcare facility?

Answer: NO

*Interpretation from November 16, 1999 HITF Meeting*

## **10. Fire watch in unoccupied areas under construction**

### **NFPA 101, 1997 Edition; Sections 7-6.1.8 and 7-7.6**

Background Information: None

Question 1 : Is it the intent that the referenced code sections require a fire watch in unoccupied areas of a healthcare occupancy under construction for the duration of the shutdown?

Answer 1: YES

Question 2 : If the answer to question 1 is yes, is the fire watch requirement applicable 24 hours a day for the duration of the shutdown?

Answer 2: YES

*Interpretation from November 16, 1999 HITF Meeting*

## **11. Marking the location of portable fire extinguishers**

### **NFPA 10, 1998 Edition; Section 1-6.2**

Background Information: Some AHJ's (inspectors) require signs marking the location of portable fire extinguishers to be mounted perpendicular to the wall in which the extinguisher cabinet is mounted. They also require this same type of signage when extinguishers are surface mounted on a wall.

The referenced code section requires only that "extinguishers mounted in cabinets or wall recesses...be marked conspicuously."

Question 1 : Is it the intent of NFPA10 to require signs marking the location of wall mounted portable fire extinguishers when not in cabinets or recesses?

Answer 1: NO

Question 2 : Where signs are installed to meet the marking requirements of the referenced code, must they be mounted perpendicular to the wall in which the extinguisher cabinet is mounted?

Answer 2: NO

Question 3 : If the answer to question 2 is no, does a conspicuous sign, including those mounted parallel to the wall, meet the intent of this section?

Answer 3: YES. NFPA 10, Section D-2-2.2 provides guidance to support this position.

*Interpretation from November 17, 1998 HITF Meeting*

## **12. Linen chutes – four foot extension**

### **NFPA 101, 1997 Edition; Section 13-5.4.1; NFPA 82, 1994 Edition; Section 3-2.2.4.**

Background: One state agency has been mandating the four foot extension on linen chutes that is required in NFPA 82, Section 3-2.2.4, be provided for existing chutes. NFPA 101, Section 13-5.4.1 requires compliance with NFPA 82 for any new chutes that may be installed in existing healthcare facilities.

Question: Is it the intent of NFPA 101, Section 13-5.4.1 to require existing chutes, that are not otherwise being altered or replaced, to comply with the four foot extension rule that is contained in NFPA 82, Section 3-2.2.4?

Answer: NO. The language of NFPA 101 is very clear that it only requires compliance with NFPA 82 (via the reference to NFPA 101, Section 7-5) for new chutes. In addition, NFPA 82, Sections 1-3.1 and 1-3.2 apply the standard to new construction and allows existing chutes to remain without be altered. NFPA 101, Sections 1-3.4, 1-3.8 and 7-5.2, exception, support this conclusion as does the general statement (specifically the last sentence) contained in NFPA 101, Section 33-1. This last statement describes the intended use of the referenced documents contained in NFPA 101.

*Interpretation from November 17, 1998 HITF Meeting*

### 13. Sprinkler/Wardrobe Issue

This item had been discussed at previous meetings, yet no formal action had ever been requested. NFPA received three letters that asked if the HITF could take a look at these items and, if appropriate, provide an interpretation. A written response from HCFA was passed out. In all three cases, since it appeared that the basis for these questions centered on HCFA enforcement of the rule, a detailed and thoughtful response from HCFA was prepared. Two primary issues were raised, the first one being that individuals should contact the regional HCFA inspectors if they are unclear on the HCFA policy on this issue. Number 2, HCFA does have a detailed policy and fix for the need, or lack of need, for sprinklers in select wardrobe units. This policy has been widely distributed to HCFA inspectors and has been used on countless occasions to remedy the sprinkler/wardrobe problem. The HITF believe that the current HCFA policy addresses this issue. If individuals believe that NFPA 13, *Standard for the Installation of Sprinkler Systems* should be changed or modified to further address this issue, then it is appropriate for proposals to be submitted for the next revision cycle of NFPA 13. In addition, it is noted that the 2000 edition of NFPA 101: 3.3.33 now defines contents and furnishings. This should help to separate furniture objects from building objects in terms of automatic sprinkler coverage. NFPA will send a response to this effect to the individuals who have raised this issue and refer them to HCFA Interpretative Guide of 30 August 1993.

*Interpretation from May 16, 2000 HITF Meeting*

### 14. Inspection of Inaccessible Fire Dampers:

This item as submitted by the Department of Veterans Affairs. NFPA 90A provides a requirement for periodic inspection of fire dampers. In some cases, modifications to building system equipment and components result in access to certain dampers being physically impossible. While any code or standard can not contemplate all future modifications or changes to a building or structure that may alter access to select equipment or component parts, both NFPA 90a as well as NFPA 101 contain language that allow these unique circumstances to be considered on a case by case basis. Based on this discussion, the HITF voting members agreed with a 4-0 vote to issue the following interpretation:

**Document to be interpreted:** NFPA 90A, section 3-4.7

Edition: Year :99

**Background Information:** Effective 1993, NFPA 90A requires maintenance of fire and smoke dampers, once every 4 years. In conducting these tests and maintenance several fire dampers were discovered totally inaccessible due to added utilities.

**Question:** Is it acceptable to exempt a fire damper from the four-year maintenance and test requirement where the physical limitations cause the damper to be inaccessible?

**Answer:** Yes, NFPA 90A: 1-3.2 and NFPA 101(2000 ed): 4.6.3 both contain provisions to allow alternative methods to be considered. As an example of this, the HITF notes the following text that is found in the 2000 edition of NFPA 101.

4.6.3 Modification of Requirements for Existing Buildings. Where it is evident that a reasonable degree of safety is provided, the requirements for existing buildings shall be permitted to be modified if their application would be impractical in the judgment of the authority having jurisdiction.

*Interpretation from May 16, 2000 HITF Meeting*



## **15. Non-required dampers – abandon in place**

**Document to be interpreted:** NFPA101, Section 1-3.13.2

Edition Year: 1997

Background Information: Section 1-3.13.2 of the 1997 Code states that existing life safety features, such as, but not limited to, automatic sprinkler, fire alarm, and standpipe systems, and horizontal exits, if not required by the code, either shall be maintained or removed. Section 4.6.12.2 of the 2000 Code now refers to existing life features 'obvious to the public', if not required by the Code, shall be either maintained or removed.

Question: Must non-required smoke dampers, fire dampers, or combination fire/smoke dampers, that are not obvious to the public, be maintained or removed?

Answer: NO.

*Interpretation from November 14, 2000 HITF Meeting*

## **16. Patient provided upholstered furniture or mattresses**

**Document to be interpreted:** NFPA101, Section 19.7.5

Edition Year: 2000

Background Information: With the increased use of the 2000 edition of the Life Safety Code we are seeing different interpretations of the Exceptions to Sections 19.7.5.2 and 19.7.5.3 of the 2000 edition. As background, these exceptions were added to the Code in the 1997 edition because Medicare/Medicaid Regulations require nursing homes to allow patients to bring in their own furniture and mattresses to allow for as much of a residential environment as possible. With out these exceptions, the Regulations would be in conflict with the Life Safety Code in nonsprinklered facilities, thus the additional requirement for the smoke detector.

Many AHJ's are interpreting that the smoke detector is required even in sprinklered buildings, which we disagree. Admittedly the language in the exceptions might be better if it stated the exception only applies to nonsprinklered rooms, but it doesn't need to state that.

The appropriate Sections in Chapter 10 clearly state that upholstered furniture and mattresses are not required to be regulated if they are located in rooms or spaces protected by sprinklers. Likewise if you look at the requirements for new health care occupancies you will note there are no requirements for furniture or mattresses provided by the patient. The reason being that sprinklers are mandated in new health care facilities. In existing sprinklered buildings it would make no sense that if the facility provided unregulated mattresses or furniture there would be no requirement for the smoke detector, but if the patient provided the mattresses or furniture there would be a requirement for the smoke detector.

Question: Is a smoke detector required to be installed in a patient sleeping room protected by an approved automatic sprinkler system when either upholstered furniture or mattresses are provided by the patient per the Exceptions to Sections 19.7.5.2 and 19.7.5.3?

Answer: NO. The provisions of 19.7.5.2 and 19.7.5.3 intend to refer to the criteria of Chapter 10. Sections 10.3.2, 10.3.3 and 10.3.4 do not specify or set any regulations for mattresses and upholstered furniture in existing healthcare occupancies that are protected with automatic sprinklers.

*Interpretation from May 20, 2003 HITF Meeting*



## **17. Locking of doors in a healthcare facility**

Document to be interpreted: NFPA 101, Section 18- 2 and 19- 2

Edition year: 2000

Background Information: The Life Safety Code (LSC) is being interpreted and enforced through Medicare & Medicaid Regulations and State enforcing authorities in a very inconsistent manner. It is clearly understood that some states have requirements that are more restrictive and different than Section 18- 2 & 19- 2 of the LSC, but the differing interpretations are occurring in states that have no requirements for locking of doors that are more restrictive than the LSC. The differing interpretations are also coming from the Federal level where to the best of my knowledge there are no requirements other than those contained in the LSC.

The Technical Committee on Health Care Occupancies in the 1988 edition of the LSC made major changes to the Code relative to the locking of doors in health care facilities. These changes were necessary to recognize how health care services were being provided in today's facilities and the need to lock doors to prevent the very real hazard of elopement by patients.

I personally submitted the proposal to expand the permissiveness to lock doors beyond psychiatric hospitals and certain areas in acute care hospitals. My substantiation for these changes was for the LSC to recognize the need to lock doors in nursing homes due to the significant increase in the population of Alzheimer and dementia patients. The Technical Committee wisely chose to expand my proposal and use the term "clinical needs of the patient and not restrict locking to only psychiatric facilities. The Committee also wisely chose not to "laundry list those illnesses that might require locking of doors and chose the words clinical needs." It is my understanding that the Technical Committee did not restrict the types of locks that could be used, the number of locks in a means of egress ' unless time delay locks were used, or require a minimum number of patients whose clinical needs required locking before doors could be locked.

It is clear that many AHJs are not comfortable or are opposed to the permissiveness of the newer editions of the LSC relative to the locking of doors when the clinical needs of the patient requires locking to prevent elopement or escape. With the adoption of the 2000 LSC for Medicare Medicaid, many AHJs are putting up roadblocks to try to prevent the locking of doors or to limit the number of doors that can be locked. Although not specifically a LSC issue, AHJs are even prohibiting the locking of doors using the requirement that a facility must maintain compliance with the requirements of the building code the facility was required to comply with when built, which did not permit the locking of doors. This borders on absurdity because when these older facilities were built, they did not even house patients whose clinical needs required locking to prevent elopement. Even if they did house these types of patients, the facilities weren't heavily fined for elopement by the very same agencies that restrict or prohibit the locking of doors to prevent elopement.

Psychiatric hospitals, which have a lower staff/patient ratio than acute care hospitals and nursing homes, have key locked doors for more than 100 years. When the Technical Committee changed the requirements in the Code for the locking of doors in the 1988 Edition , there were no incidents brought to their attention that the key locking of doors in psychiatric hospitals had resulted in the injury or death of patients due to a fire or other emergency incident. It would be nice and neat if the only hazard a health care facility

had to face was fire, but in the real world, this is not the case. Health care facilities must be given the tools to address such hazards as elopement, infection, etc.

I am requesting the following interpretations of Sections 18- 2 and 19- 2 of the 2000 Life Safety Code:

Question #1: Is it the intent of the Code to require a minimum number of patients whose clinical needs require the locking of doors be housed in a healthcare facility in order to permit the doors to be locked? **No**

Question #2: Is it the intent of the Code that patients whose clinical needs require the locking of doors be housed in the same smoke compartment or on the same floor? **No**

Question #3: If the answer to Questions #2 is no, can the patients whose clinical needs require the locking of doors be distributed throughout the facility based on the health care program of the facility? **Yes**

Question #4: Is it the intent of the Code that the clinical needs of patients relative to the need to require doors to be locked be determined by the appropriate and qualified staff of the health care facility? **Yes**

Question #5: Is it the intent of the Code to restrict the type of locking device to time delay locks? **No**

Question #6: If the answer to Questions #5 is no, can key locks, cipher locks, magnetic locks and similar locks be used as long as they can readily be unlocked by staff present when the doors are locked? **Yes**

Question #7: Are locks, other than time delay locks, and locks used on doors for stairway re-entry, required to automatically unlock upon operation of the fire alarm system or power failure? **No**

Question #8: Are the number of locked doors in the means of egress limited other than for doors using time delay locks? **No**

*Interpretation from January 23, 2004 HITF Ballot*

## **18. 18” clearance below sprinkler heads**

Document to be interpreted: NFPA 13, Section 5- 13.10

Edition year: 1999

Background Information: Section 5-5.6 states that the clearance between the sprinkler deflector and the top of storage shall be 18 in. (457 mm) or greater. Section 5-13.10 provides guidance on sprinkler protection of library stacks. This guidance allows floor to ceiling bookshelves and requires sprinklers to be installed in every aisle with a distance between sprinklers along aisles not to exceed 12 ft (3.6 m).

Question: Is it acceptable to apply the principles of NFPA 13, 5-13.10 to the storage of Medical Records on fixed open bookshelves, thereby allowing the tops of the bookshelves used for this purpose to come within less than 18 inches of the horizontal plane of the sprinkler deflector with sprinklers installed in every aisle?

Answer: Yes

*NFPA Formal Interpretation – Effective January 23, 2002*